STATE OF NEW HAMPSHIRE

DEPARTMENT OF SAFETY

DIVISION OF FIRE STANDARDS & TRAINING

BUREAU OF EMERGENCY MEDICAL SERVICES

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MEMORANDUM

TO: **AED Providers**

FROM: **William Wood, Preparedness Coordinator**

RE: **AED Forms**

On behalf of the New Hampshire Bureau of Emergency Medical Services (NHBEMS), congratulations on the purchase of your new Automated External Defibrillator (AED). In order to speed your compliance with the law and to assist in the development of your AED program, enclosed are an "AED Registry" form and an "AED Incident Report & Quality Improvement (QI)" form.

An AED Registry is being established to assist your staff and EMS responders in the event of an emergency. The Registry information will be entered into the NH 9-1-1 database and will allow the telecommunications specialists to pinpoint the location of the AED within your facility and inform the caller who may be unaware of the AED location, and to alert the EMS responders that an AED is available and being used.

The Bureau of EMS' role in the AED registry is to ensure excellence of out-of-hospital emergency medical care to all persons within the state. The AED registry will enable the Bureau to notify you in the event of product recalls, regulation and rule changes, and medical protocol changes.

The "AED Incident Report & QI" form is to be filled out after the AED is used. This allows the use of the AED to be integrated with the total care of the patient. It will also enable you to evaluate the effectiveness of your AED program.

Once again, congratulations on your purchase, if you have any questions regarding the AED Registry or QI forms, please contact the NHBEMS at (603) 271-4568.

New Hampshire Department of Safety
Bureau of Emergency Medical Services

Instructions for Completing the Automated External Defibrillation (AED) Registry Form

Listed below are instructions intended to assist you while completing the AED Registry Form. The line numbers on this form correspond with the line numbers on the AED Registry Form. If you have any questions or need further assistance completing the form, please contact the NH Bureau of EMS at (603) 271-4568 or 1-888-827-5367.

Line 1	Required by RSA 153 A:32, list the name of the entity providing the AED program.
Line 2	List the name and phone number, including area code, of the individual at entity to contact for information/questions about the AED program.
Line 3	Select an entity type by placing a checkmark next to the description that best applies to the entity. If "Other" is selected, please specify an entity type.

Line 4	Required by RSA 153 A:32, indicate the street address, city, state and zip code of building/grounds where the AED is located. This address will be entered into the NH 9-1-1 database.
Line 5	Required by RSA 153 A:32, indicate the phone number, including area code, of building/grounds where the AED is located. This number will be entered into the NH 9-1-1 database.
Line 6	Indicate the number of providers trained to use the AED at entity.
Line 7	Describe where the AED is physically located in building/grounds using reference points and landmarks to describe the precise AED location. This description will be entered into the NH 9-1-1 database.

Line 8	Indicate the name of physician authorizing use of the AED program for your organization and providing Quality Assurance oversight.
Line 9	Indicate the physician's street address, city, state, and zip code.
Line 10	Indicate the physician's phone number, including area code.

Line 11	List the AED Supplier name.
Line 12	List the AED Manufacturer name.
Line 13	List the AED serial number and AED model number.

Official Use Only-AED#_____

New Hampshire Department of Safety
Bureau of Emergency Medical Services

Automated External Defibrillation (AED) Registry Form

Entity Providing AED Information

Line 1	Name of Entity *
Line 2	Entity Contact Name_____ Phone Number (___)_____
Line 3	Entity Type: ☐ Business ☐ Industrial Setting ☐ School ☐ Stadium ☐ Municipality ☐ Corporation ☐ Store/Shopping Mall ☐ Nursing Home ☐ Assisted Living ☐ Physician Office ☐ Other, please specify_____

AED Location Information*

Line 4	Street Address of AED_____ City_____ State_____ Zip_____
Line 5	Phone Number at Street Address of AED (___)_____
Line 6	Number of AED Providers at Location_____
Line 7	Please describe the precise location of the AED in building/grounds below (using reference points/landmarks): _____ _____ _____

Physician Information

Line 8	Name of Physician Authorizing Use of AED_____
Line 9	Street Address_____ City_____ State_____ Zip_____
Line 10	Phone Number (___)

AED Information

Line 11	Name of AED Supplier_____
Line 12	Name of AED Manufacturer_____
Line 13	AED Serial Number_____ AED Model Number_____

Signature of Person Completing Form_____Date_____

Printed Name of Person Completing Form_____Date___

*Required by RSA 153-A:32

Once completed, send this form in the self-addressed, postage-paid envelope to the NH Bureau of EMS at Drive, Concord, NH 03305

Bureau of Emergency Medical Services

Instructions for Completing the Automated External Defibrillation (AED) Incident Report & Quality Improvement Form

Listed below are instructions intended to assist you while completing the AED Quality Improvement Form. The line numbers on this form correspond with the line numbers on the AED Quality Improvement Form. If you have any questions or need further assistance completing the form, please contact the NH Bureau of EMS at (603) 271-4568 or 1-888-827-5367.

Line 1	List the name of the entity providing the AED program.
Line 2	List the name of person who used the AED on the patient.
Line 3	Indicate the date and time the AED was used on the patient. For the date, indicate the month, day and year. For the time, indicate the hour and minutes of when the incident occurred.
Line 4	Indicate the patient's age and place a checkmark next to the patient's gender.

Line 5	Asking whether CPR was administered prior to use of the AED. Check whether CPR was attempted or not attempted.
Line 6	Check whether the patient's cardiac arrest was not witnessed, was witnessed by a bystander or was witnessed by the person who used the AED on the patient.
Line 7	Indicate the estimated number of minutes from the patient's cardiac arrest to when CPR was administered.
Line 8	Check whether shock was indicated or not indicated by the AED.
Line 9	Indicate the estimated number of minutes from the patient's cardiac arrest to the first shock from the AED. Also indicate the number of shocks given to the patient.
Line 10	Check the description(s) that best describes the patient after the use of the AED.

Line 11	List the name of the ambulance service that treated the patient and transported the patient to a hospital/medical facility.
Line 12	List the name of the hospital or other medical facility the patient was transferred to by the ambulance.
Line 13	List the name of the physician authorizing use of the AED program for your organization and providing Quality Assurance oversight.

New Hampshire Department of Safety

Bureau of Emergency Medical Services

Automated External Defibrillation (AED) Incident Report & Quality Improvement Form

This form is to be completed by the entity's AED Program representative or the AED user. Once completed, send a copy of this report to the NH Bureau of EMS at 33 Hazen Drive, Concord, NH 03305.

Line 1	Name of Entity Providing AED_____
Line 2	Name of AED Operator_____
Line 3	Date of Incident_____/_____/_____ Time of Incident_____:_____
Line 4	Patients Age_____ Patient's Gender(☐) Male (☐) Female

Line 5	CPR Prior to Defibrillation? (☐) Attempted (☐) Not Attempted
Line 6	Cardiac Arrest: (☐) Not Witnessed (☐) Witnessed by Bystander (☐) Witnessed by AED Provider
Line 7	Estimated Time (in minutes) From Arrest To CPR____:____
Line 8	Shock: (☐) Indicated (☐) Not Indicated
Line 9	Estimated Time (in minutes) From Arrest to First Shock:____:____ Number of Shocks:_____
Line 10	Patient Outcome at Incident Site: (check all that apply) (☐) Return of Pulse and Breathing (☐) No Return of Pulse or Breathing (☐) Return of Pulse with No Breathing (☐) Became Responsive (☐) Return of Pulse, Then Loss of Pulse (☐) Remained Unresponsive

Line 11	Name of Transporting Ambulance_____
Line 12	Name of Facility Patient Transported To_____
Line 13	Name of Physician Authorizing Use of AED_____

Signature of AED Provider_____Date_____